HOME HEALTH CARE SERVICES PAYMENT SYSTEM

*payment***basics**

Beneficiaries who are generally restricted to their homes and need skilled care (from a nurse, physical, or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency (HHA) personnel visit beneficiaries' homes to provide services:

- skilled nursing care,
- physical, occupational, and speech therapy,
- medical social work, and
- home health aide services.

Beneficiaries are not required to make any copayments for these services.

About 2.6 million beneficiaries used home health care in 2003. Medicare's payments to HHAs were $10 billion, accounting for only 4 percent of Medicare's total payments, but accounting for a large share of HHAs' total revenues. About 7,000 agencies participated in the program in 2003.

In October 2000, CMS adopted a new prospective payment system (PPS) that pays HHAs a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment.

The primary challenge for the PPS is to set payment rates that are adequate to ensure beneficiaries' access to appropriate home care services. Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, post-hospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Certain beneficiaries who have no preceding hospital stay and are capable of spending significant time outside their homes are now eligible to receive covered services furnished in an unlimited number of home care episodes.

The care Medicare buys

Medicare purchases home health services in units of 60-day episodes. To capture differences in expected resource use, patients receiving 5 or more visits are assigned to 1 of 80 home health resource groups (HHRGs) based on clinical and functional status and service use as measured by the Outcome and Assessment Information Set (OASIS) (Figure 1).

Setting the payment rates

The HHRGs range from groups of relatively uncomplicated patients to those of patients who have severe medical conditions, severe functional limitations, and need extensive therapy. Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for HHRGs in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—for geographic factors and case mix (Figure 2).

To adjust for geographic factors, the per-episode payment rate is divided into labor and non-labor portions; the labor portion—77 percent—is adjusted by a version of the hospital wage index to account for

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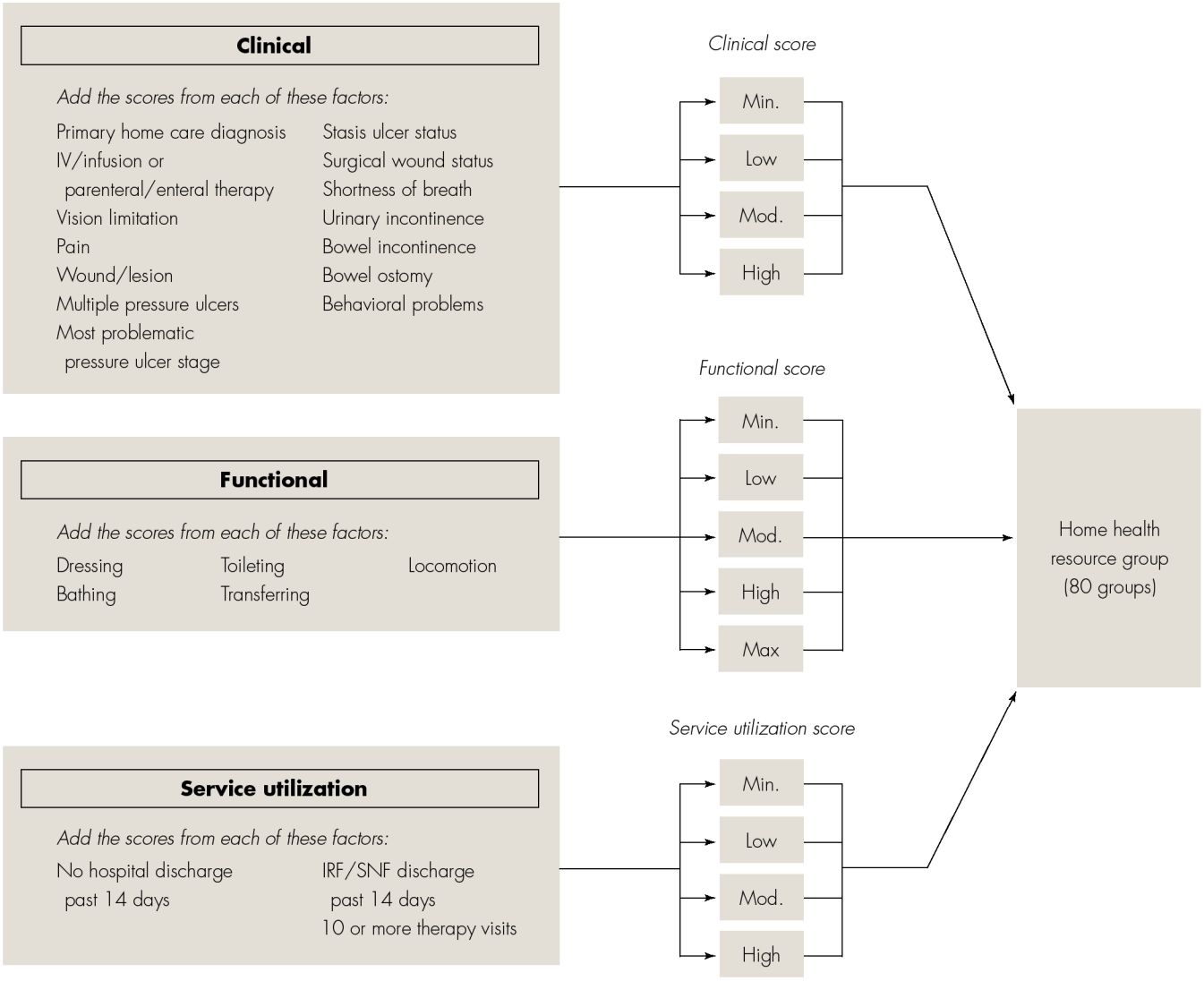
Figure 1 Clinical, functional, and service information from OASIS determines patients' home health resource group



Note: OASIS (Outcome and Assessment Information Set), IV (intravenous), IRF (inpatient rehabilitation facility), SNF (skilled nursing facility).

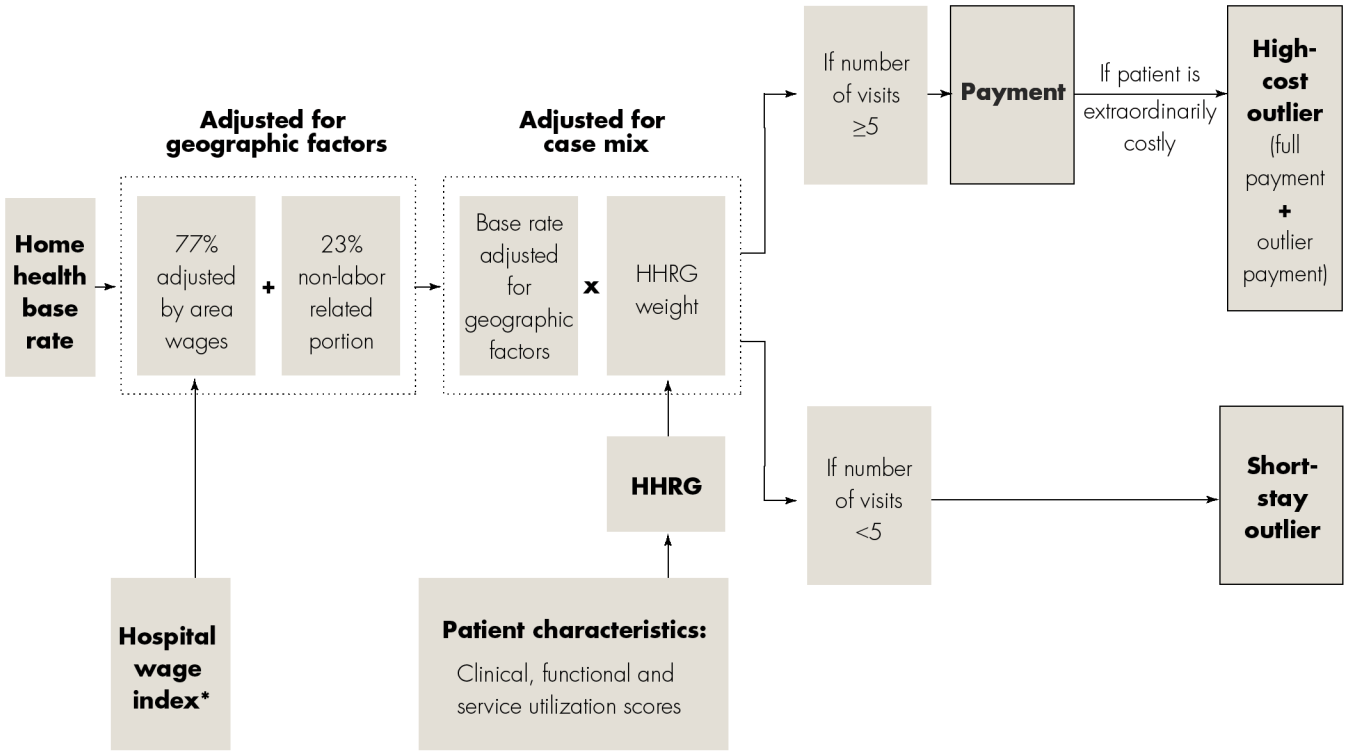
Source: CMS 2000.

geographic differences in the input-price level in the local market for labor-related inputs to home health services. Unlike most other Medicare payment systems, the local area adjustment for home health services is determined by the beneficiary's residence. The total payment is the sum of the adjusted labor portion and the nonlabor portion.

To adjust for case mix, the base rate adjusted for geographic factors is multiplied by the relative weight for each HHRG.

The initial national average base payment amount for a typical home health episode is intended to reflect the projected amount providers would have received per episode under the previous payment system, updated for inflation. Because providers receive payments on a per-visit basis for patients who have fewer than 5 visits in 60 days, the base amount was adjusted to reflect this policy. It was also reduced by 5

Figure 2 Home health care services prospective payment system



Note: HHRG (home health resource group).
*Home health care services prospective payment system uses a version of the hospital wage index called the 'pre-floor, pre-classification hospital wage index.'

percent to account for anticipated high-cost outlier payments.

When a patients' episode of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by 0.65 times the standard base payment amount (a portion of which is adjusted for local wages). To determine eligibility for an outlier payment, episode costs are imputed by multiplying the estimated national average per visit costs by type of visit—adjusted to reflect local input prices—by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference in addition to the episode payment.

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the update cycle from a fiscal to a calendar year and lowered the update for home health payments by 0.8 percent for 2004, 2005, and 2006. In April 2004, the law restarted for one year the 5 percent add-on payment for rural areas (that had expired in April 2003). The MMA also suspended the collection of patient assessment instrument—OASIS—for non-Medicare and non-Medicaid patients. ■